DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Dental Providers
Managed Care Plans

Memorandum No: 04-03 MAA
Issued: February 23, 2004

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

For Information Call:
1-800-562-6188

Subject: Dental Program Changes and Updates

Effective for dates of service on and after March 1, 2004, the Medical Assistance Administration (MAA) will implement the following technical changes and updates discussed in this memorandum.

Rate Change for Partial Dentures for Adults and Children

Effective for dates of service on and after March 1, 2004, MAA is updating the rates for partial dentures.

CDT* Procedure Code	Brief Description	3/1/04 Maximum Allowable Fee
D5213	Maxillary partial denture	$448.00
D5214	Mandibular partial	$448.00

Periodontal Maintenance Change for Adults

These periodontal maintenance changes **do not affect** the frequency of visits already allowed for those clients of the Division of Developmental Disabilities (DDD).

For all other eligible clients age 21 and older, periodontal maintenance is now allowed **every six months,** beginning six months **after** the completion of periodontal scaling and root planing or surgical treatment. Original description/limitations as detailed in MAA's Dental Billing Instructions, dated October 2003, still apply.

CDT Procedure Code	Brief Description	Clients 21 years and older
D4910	Periodontal maintenance	$50.00

*CDT – Current Dental Terminology

Coverage Changes

Retroactive to dates of service on and after August 1, 2003, MAA will reimburse providers for CDT codes D7241 and D7250 for adults.

CDT Procedure Code	Brief Description	8/1/03 Maximum Allowable Fee Clients 21 years and older
D7241	Removal of impacted tooth **(Requires Prior Authorization)**	$180.00
D7250	Surgical removal	$48.34

Updated Requirements for Immediate and Partial Dentures

- Submit all radiographs for immediate and partial dentures when requesting prior authorization.
- When submitting radiographs, send appropriate duplicates. Keep originals in the client's file. Radiographs may or may not be returned at the discretion of MAA.
- Periodontal charting, when appropriate, for immediate and partial dentures must be available **upon request** by MAA's dental consultant.
- List all missing teeth for both arches when requesting prior authorizations.
- MAA covers denture relines once in a five-year period. Relines do not require prior authorization.

Clarification of Anesthesia Procedures for Adults

MAA covers general anesthesia for DDD clients for all covered dental procedures. For all other eligible clients, MAA covers general anesthesia **only** when medically necessary, and only for those oral surgery CPT* codes listed in MAA's Dental Program Billing Instructions, dated October 2003, pages F.5 – F.15.

In addition, MAA covers conscious sedation and parenteral or multiple oral agents for DDD clients for all covered dental procedures. For all other eligible clients, conscious sedation and parenteral or multiple oral agents are covered **only** when medically necessary, and only for those oral surgery CPT codes listed in MAA's Dental Program Billing Instructions, dated October 2003, pages F.5 – F.15, and those surgical extraction CDT codes listed on page E.35.

*CPT – Current Procedural Terminology

Changes to Other Restorative Services

MAA has deleted the bullet stating "MAA does not pay for a core buildup when a permanent or temporary crown is being placed on the same tooth." The new description reads:

CDT Procedure Code	Description/Limitations	Prior Auth	10/1/03 Maximum Allowable Fee Clients 21 years and over
D2950	**Core Build-up (including any pins)** MAA pays for core buildup on an anterior or a posterior tooth, including any pins, which is allowed once per client, per provider, in a two-year period, subject to the following: • MAA does not pay for a core buildup when placed in combination with any other restoration on the same tooth on the same date of service • Tooth designation is required	No	$70.00

Change to Professional Visit Reimbursement for House/Extended Care Facility Calls for Adults

The following change has been made to the way house/extended care facility calls are reimbursed. Prior authorization is **not** required.

CDT Procedure Code	Description	10/1/03 Maximum Allowable Fee Clients age 21 years and older
D9410	House/extended care facility call. Allowed once per day, per facility, per provider. **Limited to two total calls per day.**	$31.53

Attached are replacement pages D.15/D.16, D.37/D.38, E.5/E.6, E.9/E.10, E.15/E.16, and E.23 through E.40 for MAA's Dental Program Billing Instructions, dated October 2003.

To obtain this numbered memorandum electronically, go to MAA's website at http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

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Where should I send requests for prior authorization?

Mail your request to:

Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require radiographs
Fax: (360) 586-5299

☞ **Note**: Include return fax number on all faxed requests for prior authorizations.

Expedited Prior Authorization (EPA)

When do I need to bill with an EPA number?

Dental services that are listed as **"Requires Expedited Prior Authorization"** in the fee schedule must have the assigned EPA number for that procedure on the ADA Claim Form when billing. By placing the appropriate EPA number on the ADA Claim Form when billing MAA, dental providers are verifying that the EPA criteria for that procedure code have been met.

Once the EPA criteria are met, use the nine-digit EPA number listed next to the procedure code in the fee schedule.

☞ **Note:** Dental providers are reminded that these unique EPA numbers are ONLY for the procedure codes listed in the fee schedule as "Requires Prior Authorization."

Dental Fee Schedule for Children

Guide to using the fee schedule

Column 1: Procedure Code (ADA CDT)
Column 2: Description/Limitations
Column 3: Prior Auth? Is prior authorization required?
Column 4: Maximum Allowable – Children 0 through 18 years of age.
Column 5: Maximum Allowable – Adults 19 through 20 years of age.

- Always bill your usual and customary fee(s) (not MAA's maximum allowable amount).
- For certain procedures, there are separate reimbursement rates for children (0 through 18 years of age) and clients (19 through 20 years of age). These are indicated in the maximum allowable column in the fee schedule.

Remember: You may bill only after services have been provided, but we must receive your bill within 365 days from the date of service.

Unless otherwise specified, MAA uses the descriptions of the ADA codes as listed in the CDT manual.

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 0-18 yrs	10/1/03 Maximum Allowable 19 –20 yrs

Complete Dentures (including six months post-delivery care)

- The MAA dental program covers one set of dentures in a ten-year period.
- Dentures placed immediately must be of structure and quality to be considered the permanent set. Transitional dentures are not covered.
- No additional reimbursement is allowed for denture insertions.

D5110	**Complete denture – maxillary** (upper)	No	$398.00	$398.00
D5120	**Complete lower – mandibular** (lower)	No	$398.00	$398.00
D5130	**Immediate denture – maxillary** (upper) Appropriate radiographs must be submitted to MAA.	No	$398.00	$398.00
D5140	**Immediate denture – mandibular** (lower) Appropriate radiographs must be submitted to MAA.	No	$398.00	$398.00

Partial Dentures (including six months post-delivery care)

- One partial per arch is covered.
- D5211 and D5212 are covered for one or more teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing three or more teeth per arch, excluding wisdom teeth.
- MAA pays for partials covered by MAA once in five years.

D5211	**Maxillary partial denture – resin base** (includes any conventional clasps, rests and teeth)	No	$240.00	$240.00
D5212	**Mandibular partial denture – resin base** (including any conventional clasps, rests and teeth)	No	$240.00	$240.00
D5213	**Maxillary partial denture – cast metal framework with resin denture bases** (including any conventional clasps, rests and teeth)	No	$448.00 (New rate effective 3/1/04)	$448.00 (New rate effective 3/1/04)
D5214	**Mandibular partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth)	No	$448.00 (New rate effective 3/1/04)	$448.00 (New rate effective 3/1/04)

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 0-18 yrs	19 –20 yrs

Lab and Professional Fees for Complete/Partial Dentures

D5899	**Unspecified removable prosthodontic procedure** Laboratory and professional fees may be paid for complete dentures or partial dentures if the patient: • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. **Requires prior authorization from MAA.** When requesting prior authorization, you must attach an invoice listing laboratory prescriptions and fees.	**Yes**	**By Report**	**By Report**

Adjustments to Dentures and Partials

- No allowance for adjustments for 6 months following placement.
- Adjustments done during this period are included in denture/partial allowance.

D5410	**Adjust complete denture – maxillary** (upper)	No	$16.48	$15.76
D5411	**Adjust complete denture – mandibular** (lower)	No	$16.48	$15.76
D5421	**Adjust partial denture – maxillary** (upper)	No	$16.48	$15.76
D5422	**Adjust partial denture – mandibular** (lower)	No	$16.48	$15.76

Repairs to Complete Dentures

D5510	**Repair broken complete denture base** Arch designation required.	No	$37.09	$34.68
D5520	**Replace missing or broken teeth – complete denture** Use for initial tooth. Tooth designation required.	No	$32.97	$28.73

k) **Periodontal maintenance**, which is:
   i. Allowed for DDD clients (see page E.6);
   ii. Allowed every six months for clients age 21 and older;
   iii. Allowed only when the client has been previously treated for periodontal disease, including surgical or non-surgical periodontal therapy;
   iv. Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
   v. Allowed when the client's clinical condition meets existing periodontal guidelines;
   vi. Allowed when periodontal maintenance starts at least six months after completion of periodontal scaling and root planing or surgical treatment and paid only at six-month intervals; and
   vii. Not reimbursed when the periodontal maintenance is performed on the same date of service as periodontal scaling and root planing, gingivectomy, or gingivoplasty.
   viii. Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period.

l) **Dentures and partial dentures** (see page E.28 for limitations);

m) **Simple extractions** (includes local anesthesia, suturing and routine postoperative care);

n) **Surgical extractions**, subject to the following:

   i. Includes local anesthesia, suturing, and routine postoperative care; and
   ii. Requires documentation and radiographs in the client's file to support soft tissue, partially bony, or completely bony extractions.

> **Excludes teeth 7, 8, 9, 10, 23, 24, 25, and 26** which are considered simple extractions and must be billed as such. To request MAA's consideration for surgical reimbursement for these teeth, submit your request using the Prior Authorization process listed on page E.13. In an emergency the Prior Authorization may be done after the extraction

o) **Medically necessary oral surgery** when coordinated with the client's managed care plan (if any);

p) **Palliative (emergency) treatment** of dental pain and infections, minor procedures, which is

   i. Allowed once per client, per day.
   ii. Reimbursed only when performed on a different date from:
      A. Any other definitive treatment necessary to diagnose the emergency condition; and
      B. Root canal therapy.
   iii. Reimbursed only when a description of the service provided is included in the client's record.

What additional dental services are covered for DDD clients? [Refer to WAC 388-535-1255(3)]

For clients of the Division of Developmental Disabilities, MAA allows additional services as follows:

a) One of the following teeth cleaning services or combination of teeth cleaning services, subject to the limitations listed:

   i. Prophylaxis or periodontal maintenance, three times per calendar year;
   ii. Periodontal scaling and root planning, two times per calendar year;
   iii. Prophylaxis or periodontal maintenance, two times per calendar year, and periodontal scaling and root planning, two times per calendar year.

b) Gingivectomy or gingivoplasty;
c) Nitrous oxide; and
d) Behavior management that requires the assistance of one additional dental professional staff.

What dental services are covered when provided in a non-office setting? [Refer to WAC 388-535-1255(4) and 388-535-1270(4)]

Providers who bill using CDT codes for the services below must obtain Prior Authorization from MAA. See page E.12.

MAA covers dental services that are medically necessary and provided in a non-office setting (e.g., short stay, ambulatory surgery centers) under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page E.10; and
c) A hospital call, including emergency care, allowed one per day, per client, per provider.

What dental services are covered when provided in a hospital?

Nonemergent oral surgeries performed in an inpatient setting are noncovered. Exceptions to this policy are evaluated for DDD clients whose surgery cannot be performed in an office setting or for medically necessary reconstructive surgery. Exceptions require prior written authorization for the inpatient hospitalization.

GA-U/GA Covered Procedure Codes:

CDT	11641	13153	21406	41008
D0140	11642	13160	21421	41009
D0220	11643	14040	21422	41010
D0230	11644	20220	21423	41015
D0330	11646	20520	21431	41016
D3310	12001	21030	21432	41017
D7140	12002	21034	21433	41018
D7210	12004	21040	21435	41100
D7220	12005	21041	21436	41105
D7230	12011	21044	21445	41108
D7240	12013	21045	21452	41110
D7241	12014	21046	21453	41112
D7250	12015	21047	21454	41113
D9110	12016	21141	21461	41114
D9220	12031	21142	21462	41825
D9420	12032	21143	21470	41826
D9630	12034	21336	30580	41827
	12035	21337	40800	42100
	12051	21344	40801	42104
CPT	12052	21345	40804	42106
11100	12053	21346	40805	42180
11101	12054	21347	40808	42182
11440	12055	21348	40810	42235
11441	13131	21355	40812	
11442	13132	21356	40814	
11443	13133	21360	41000	
11444	13150	21365	41005	
11446	13151	21366	41006	
11640	13152	21385	41007	

See page E.17 – Dental Fee Schedule for Maximum Allowable Fees, Limitations, and Additional Required Documentation

What dental services are not covered for adults?

[Refer to WAC 388-535-1265(1) and (2)]

MAA does not cover the following dental services unless the services are:

- Included in a MAA-waivered program; or
- Part of one of the Medicare programs for Qualified Medicare Beneficiaries (QMB), except for QMB-only, which is not covered.

MAA does **not cover** the following dental-related services for adults:

a) **Any services specifically excluded by statute**.

b) **More costly services** when less costly, equally effective services as determined by the department are available;

c) Services, **procedures**, treatments, devices, drugs, or application of associated services which the department of the Centers for Medicare and Medicaid Services (CMS) consider **investigative or experimental** on the date the services were provided;

d) Coronal polishing;

e) **Fluoride treatments (gel or varnish) for adults**, unless the clients are:

i. Clients of the Division of Developmental Disabilities;
ii. Diagnosed with xerostomia, age 19-64, in which case the provider must request **prior authorization**; or
iii. High-risk adults, 65 years of age and older. High-risk means the client has at least one of the following:

A. Rampant root surface decay; or
B. Xerostomia.

f) **Restorations** for wear on any surface of any tooth without evidence of decay through the enamel or on the root surface**.**

g) Flowable composites for interproximal or incisal restorations;

h) Nitrous oxide, except as provided for clients of the Division of Developmental Disabilities (see page E.6);

i) Behavior management, except as provided for clients of the Division of Developmental Disabilities (see page E.6);

j) Occlusal adjustments;

How do I obtain written prior authorization?

[Refer to WAC 388-535-1280(1)]

MAA requires a dental provider who is requesting prior authorization to submit sufficient, objective, clinical information to establish medical necessity.

The request must be submitted in writing on a completed ADA Claim Form and include the following:

- The client's name and date of birth;
- The client's patient identification code (PIC);
- The provider's name and address;
- The provider's telephone number (including area code); and
- The provider's assigned 7-digit MAA provider number.

Also…

- The physiological description of the disease, injury, impairment, or other ailment;
- The most recent and relevant radiographs that are identified with client name, provider name, and date the radiographs were taken. *Radiographs should be duplicates as originals are to be maintained in the client's chart.*
- The proposed treatment;
- Periodontal charting (when radiographs do not sufficiently support the medical necessity for the extractions);
- Study model (if requested); and
- Photographs (if requested).

(Refer to Section H, How to Complete the ADA Claim Form.)

If MAA approves your request, the ADA Dental Claim Form will be returned to you with an authorization number. **This original form** is to be completed and submitted for payment. Keep a copy for your records.

Where should I send requests for prior authorization?

Mail your request, along with required radiographs, to:

Program Management and Authorization Section
PO Box 45506
Olympia, WA 98504-5506

For procedures that do not require radiographs
Fax: (360) 586-5299

☞ **Note**: Include return fax number on all faxed requests for prior authorizations.

Expedited Prior Authorization (EPA)

When do I need to bill with an EPA number?

Dental services that are listed as **"Requires Expedited Prior Authorization"** in the fee schedule must have the assigned EPA number for that procedure on the ADA Claim Form when billing. By placing the appropriate EPA number on the ADA Claim Form when billing MAA, dental providers are verifying that the EPA criteria for that procedure code have been met.

Once the EPA criteria are met, use the 9-digit EPA number listed next to the procedure code in the fee schedule.

☞ **Note:** Dental providers are reminded that these unique EPA numbers are ONLY for the procedure codes listed in the fee schedule as "Requires Prior Authorization."

Exceeding Limitations or Restrictions
A request to exceed stated limitations or other restrictions on covered services is called a limitation extension (LE), which is a form of prior authorization. MAA may evaluate and approve requests for LE for dental-related services when medically necessary, as determined by MAA, under the provisions of WAC 388-501-0165. **[WAC 388-535-1080(7)]**

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Resin-Based Composite Restorations

(Composite/Glass Ionomer)

- Composite restorations are covered once in a two-year period for the same surface of the same tooth, per client, per provider subject to the following:
  - ✓ Replacement of restorations is not allowed within a two-year period, unless the restoration has an additional adjoining carious surface, then all restored surfaces will be covered.
- Multiple restorations involving the proximal and occlusal surfaces of the same tooth are considered to be a single multi-surface restoration, except for teeth 2, 3, 14, and 15. Payment is limited to that of a single multi-surface restoration.
- Any interproximal restoration that does not involve the incisal angle in the anterior teeth is considered to be a **two-surface** restoration.
- Interproximal restorations involving the incisal angle are considered to be either a three or four surface restoration. All surfaces must be listed for payment.
- Buccal or lingual class V restorations may be billed as a separate single surface restoration.
- A maximum of six surfaces for an anterior or posterior tooth are allowed once per client, per provider, in a two-year period.
- MAA covers flowable composites as a restoration only when used with a cavity preparation for a carious lesion that penetrates the enamel (see page E.3).
- MAA does not cover flowable composites for interproximal or incisal restorations.

D2330	**Resin-based composite – 1 surface, anterior** Tooth and surface designations required.	No	$34.68
D2331	**Resin-based composite – 2 surfaces, anterior** Tooth and surface designations required.	No	$52.54
D2332	**Resin-based composite – 3 surfaces, anterior** Tooth and surface designations required.	No	$67.25
D2335	**Resin-based composite – 4 or more surfaces, anterior** Tooth and surface designations required.	No	$79.87
D2391	**Resin-based composite – 1 surface, posterior** Tooth and surface designations required.	No	$36.04
D2392	**Resin-based composite – 2 surfaces, posterior** Tooth and surface designations required.	No	$48.38
D2393	**Resin-based composite – 3 surfaces, posterior** Tooth and surface designations required.	No	$69.83
D2394	**Resin-based composite, 4 or more surfaces, posterior** Tooth and surface designations required.	No	$70.00

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 21 yrs & up

Other Restorative Services

D2950	**Core build-up (including any pins)** MAA pays for a core buildup on an anterior or a posterior tooth, including any pins, once per client, per provider, in a two-year period, subject to the following: • MAA does not pay for a core buildup when placed in combination with any other restoration on the same tooth on the same date of service; and • Tooth designation is required.	No	$70.00

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 21 yrs & up

Endodontic

Root Canal Therapy

D3310	**Anterior (excluding final restorations)** • Excludes initial diagnostic radiographs; • Includes pre-treatment diagnostic tests; • Includes follow-up treatment; • Includes diagnostic radiographs taken during the root canal procedure; and • Not covered for primary teeth. Tooth designation is required.	No	$165.00

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Periodontics

Surgical Services

D4210	**Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant** Quadrant designation required. Allowed once every three years	No	$52.54 **DDD clients only**

Periodontal Scaling and Root Planing

- Allowed for DDD clients (see page E.6).
- Allowed for clients age 19 and older.
- Allowed only when the client has radiographic evidence of periodontal disease.
- There must be supporting documentation in the client's record, including complete periodontal charting and a definitive periodontal diagnosis.
- Allowed only when the client's clinical condition meets existing periodontal guidelines.
- Allowed once per quadrant in 24-month period, quadrant designation is required.
- Not allowed when performed on the same date of service as oral prophylaxis, periodontal maintenance, gingivectomy or gingivoplasty.
- Ultrasonic scaling, gross scaling, or gross debridement procedures may be included in the procedure, but are not substitutes for, periodontic scaling and root planing.

D4341	**Periodontal scaling and root planing, four or more contiguous teeth or bounded teeth spaces, per quadrant**	No	$26.28
D4342	**Periodontal scaling and root planing (1-3 teeth, per quadrant)**	No	$13.66

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 21 yrs & up

Periodontal Maintenance

- Allowed for DDD clients three times per year;
- Allowed every six months for all other eligible clients age 21 and older;
- Allowed only when the client has been previously treated for periodontal disease, including surgical or non-surgical periodontal therapy;
- Allowed when supporting documentation in the client's record includes a definitive periodontal diagnosis and complete periodontal charting;
- Allowed when the client's clinical condition meets existing periodontal guidelines;
- Allowed when periodontal maintenance starts at least six months after completion of periodontal scaling and root planing or surgical treatment and paid only at six-month intervals.
- Not reimbursed when the periodontal maintenance is performed on the same date of service as oral prophylaxis or periodontal scaling and root planing, gingivectomy, or gingivoplasty.
- Reimbursed only if oral prophylaxis is not billed for the same client within the same 12-month period.

D4910	**Periodontal Maintenance** [full mouth – not per quadrant]	No	$50.00

Dentures/Partial Dentures

ALL Dentures, Partial Dentures, and Replacement of Dentures or Partial Dentures REQUIRE PRIOR AUTHORIZATION
See page E.13 for details on requesting prior authorization.

Dentures, partial dentures require labeling in accordance with RCW 18-32.695.

Dentures

[Refer to WAC 388-535-1290(2) and (3)]

MAA covers the following for eligible adults:

- Only one complete maxillary and one complete mandibular denture per client in a ten-year period, when constructed after the client had been without teeth for a period of time; or

- Only one immediate maxillary denture and one immediate mandibular denture allowed per client, per lifetime, and only when constructed prior to the removal of the client's teeth.

The dentures must be of an acceptable structure and quality to meet the standard of care.
MAA does not cover transitional dentures.

Partial Dentures

[Refer to WAC 388-535-1290(2)(c)]

MAA covers the following for eligible adults:

- Only one maxillary partial denture (resin) and one mandibular partial denture (resin) to replace one, two, or three missing anterior teeth per arch, allowed per client in a ten-year period; or

- Only one maxillary partial denture (cast metal framework) and one mandibular partial denture (cast metal framework) allowed per client in a ten-year period to replace:

    a. Any combination of at least six anterior and posterior missing teeth per arch excluding wisdom teeth; or
    b. At least four anterior missing teeth per arch.

Prior Authorization for Complete Dentures

[Refer to WAC 388-535-1290(1)]

- MAA requires prior authorization for complete dentures.
- Requests for prior authorization must include:

  - ✓ Whether the client was successfully able to wear dentures in the past; and
  - ✓ If not, reason why not and why client would be able to wear dentures now.

Prior Authorization for Immediate Dentures and Partial Dentures [Refer to WAC 388-535-1290(1)]

Clinical justification is required from a dentist for immediate dentures and partial dentures.

- MAA requires prior authorization for immediate dentures and partial dentures, described in this section.
- Submit all radiographs for immediate and partial dentures when requesting prior authorization.
- When submitting radiographs, send appropriate duplicates. Keep the originals in the client's file. Radiographs may or may not be returned at the discretion of MAA.
- For immediate dentures, the client's dentist must initiate a request for authorization from MAA. The client's dentist must provide periodontal charting when appropriate (**only upon request of MAA's dental consultant**), periodontal diagnosis, and radiographs.
- For partial dentures, the client's dentist/denturist must initiate request for authorization from MAA and provide:
  - ✓ charting of missing teeth for both arches;
  - ✓ periodontal charting;
  - ✓ periodontal diagnosis;
  - ✓ radiographs;
  - ✓ whether the client has current partials; and
  - ✓ why the partial denture cannot be relined or repaired.
- If a different dentist/denturist is providing the immediate or partial dentures, that dentist/denturist must contact MAA for the prior authorization number.

Relines

[WAC 388-535-1290(9)(10)]

- **Relines do not require prior authorization.**
- MAA covers complete denture and partial denture relines only once in a five-year period.
- MAA does not require prior authorization for repairs.
- MAA does not pay separately for relines that are done within six months of the seat date. For this time period, these procedures are included in the reimbursement for the dentures and partial dentures.

Repairs

[WAC 388-535-1290(5)]

- MAA covers complete denture and partial denture repairs, when medically necessary.
- MAA does not require prior authorization for repairs.
- MAA does not pay separately for repairs that are done within six months of the seat date. For this time period, these procedures are included in the reimbursement for the dentures and partial dentures.

Replacement of Complete Dentures or Partial Dentures

[Refer to WAC 388-535-1290(2)(d) and (6)]

MAA covers the following for eligible adults:

- Only one replacement of a complete maxillary denture and one replacement of a complete mandibular denture allowed per client in a ten-year period; or

- Only one replacement of a maxillary partial denture (cast metal framework) and a mandibular partial denture (cast metal framework) allowed per client in a ten-year period.

Replacement of complete dentures and partial dentures must:

- Replace a complete maxillary denture, a complete mandibular denture, a maxillary partial denture (cast metal framework) or a mandibular partial denture (cast metal framework);
- Replace dentures or partial dentures that are no longer serviceable and are unable to be relined;
- Replace dentures or partial dentures that are damaged beyond repair; and
- Replace dentures or partial dentures that a client has been able to wear successfully.

Billing

[WAC 388-535-1290(7) and (8)]

For billing purposes, the provider must:

a. Use the delivery date as the service date for the dentures and partial dentures; or
b. Use the impression date as the service date for dentures and partial dentures only when:

    i. Related dental services, including laboratory services, were provided during a client's eligible period;
    ii. The client is not eligible at the time of delivery; and
    iii. The client does not return to obtain the dentures or partial dentures.

The provider must document in the client's record:

a. Written laboratory prescriptions;
b. Receipts for laboratory fees;
c. Receipts for laboratory records;
d. Charting of missing teeth for partial dentures; and
e. Documentation that justifies the placement or replacement of dentures or partial dentures.

Laboratory and Professional Fees for Dentures/Partial Dentures [Refer to WAC 388-535-1290(9)]

MAA does not pay separately for laboratory and professional fees for dentures and partial dentures. However, MAA may partially reimburse for these fees when the provider obtains prior authorization and the client:

- Dies;
- Moves from the state;
- Cannot be located; or
- Does not participate in completing the dentures.

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 21 yrs & up

Complete Dentures (including six months post-delivery care)

- The MAA dental program covers one maxillary and one mandibular denture in a 10-year period.
- No additional reimbursement is allowed for denture seat/delivery.
- D5110 through D5140 **require prior authorization from MAA.**

D5110	**Complete denture – maxillary** (upper) **Requires Prior Authorization**	**Yes**	$398.00
D5120	**Complete lower – mandibular** (lower) **Requires Prior Authorization**	**Yes**	$398.00
D5130	**Immediate denture – maxillary** (upper) Appropriate radiographs must be submitted to MAA. **Requires Prior Authorization**	**Yes**	$398.00
D5140	**Immediate denture – mandibular** (lower) Appropriate radiographs must be submitted to MAA. **Requires Prior Authorization**	**Yes**	$398.00

Partial Dentures (including six months post-delivery care)

- D5211 and D5212 are covered for 1-3 missing anterior teeth, excluding wisdom teeth.
- D5213 and D5214 are covered only when replacing any combination of 6 anterior and posterior missing teeth per arch or 4 or more anterior missing teeth per arch.
- D5211 through D5214 **require prior authorization from MAA.**

D5211	**Maxillary partial denture – resin base** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	**Yes**	$240.00
D5212	**Mandibular partial denture – resin base** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	**Yes**	$240.00
D5213	**Maxillary partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	**Yes**	$448.00 (New rate effective 3/1/04)
D5214	**Mandibular partial denture – cast metal framework with resin denture bases** (includes any conventional clasps, rests and teeth) **Requires Prior Authorization**	**Yes**	$448.00 (New rate effective 3/1/04)

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Lab and Professional Fees for Complete/Partial Dentures

D5899	**Unspecified removable prosthodontic procedure** Laboratory and professional fees may be paid for complete dentures or partial dentures if the patient: • Dies; • Moves from the state; • Cannot be located; or • Does not participate in completing the dentures. **Requires prior authorization from MAA.** **When requesting prior authorization, attach an invoice listing laboratory prescriptions and fees.**	Yes	**By Report**

Repairs to Complete Dentures

D5510	**Repair broken complete denture base** Arch designation required.	No	$34.68
D5520	**Replace missing or broken teeth – complete denture** Use for initial tooth. Tooth designation required.	No	$28.73

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Repairs to Partial Dentures

D5610	**Repair resin denture base** Arch designation required.	No	$32.58
D5620	**Repair cast framework** Arch designation required.	No	$48.34
D5630	**Repair or replace broken clasp** Arch designation required.	No	$48.34
D5640	**Replace broken teeth – per tooth** Use for initial tooth. Tooth designation required.	No	$28.22
D5650	**Add tooth to existing partial denture** Tooth designation required.	No	$36.78
D5660	**Add clasp to existing partial denture** Tooth designation required.	No	$48.34

Denture Relining

- Relines are included in allowance for dentures if service is provided within first six months of placement of dentures.
- Reline of partial or full dentures is not allowed more than once in a 5-year period.

D5750	**Reline complete maxillary denture (laboratory)**	No	$105.08
D5751	**Reline complete mandibular denture (laboratory)**	No	$105.08
D5760	**Reline maxillary partial denture (laboratory)**	No	$96.68
D5761	**Reline mandibular partial denture (laboratory)**	No	$96.68

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 21 yrs & up

Oral Surgery – Dentists

MAA covers dental services that are medically necessary and provided in a non-office setting under the direction of a physician or dentist for:

a) The care or treatment of teeth, jaws, or structures directly supporting the teeth, if the procedure requires hospitalization;
b) Short hospital stays or ambulatory surgery centers when the procedure cannot be done in an office setting (See "What dental-related services are not covered," page E.10; and
c) A hospital call, including emergency care, allowed once per day, per client, per provider.

Simple Extraction

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7140	**Extraction, erupted tooth or exposed root (elevation and/or forceps removal)**	No	$33.14

Surgical Extractions

(includes local anesthesia, suturing, if needed, and routine postoperative care)

D7210	**Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth** Anterior teeth (7-10 and 23-26) require prior authorization and must be justified with radiographs. Tooth designation is required.	See desc	$65.00
D7220	**Removal of impacted tooth – soft tissue** Tooth designation is required.	No	$76.71
D7230	**Removal of impacted tooth – partially bony** Tooth designation is required.	No	$120.00
D7240	**Removal of impacted tooth – completely bony** Allowed only when pathology is present. Tooth designation is required.	No	$140.00
D7241	**Removal of impacted tooth - completely bony with unusual surgical complications** Allowed only when pathology is present. Tooth designation is required.	**Yes**	$180.00 **(effective 8/1/03)**
D7250	**Surgical removal of residual tooth roots (cutting procedure)** Extraction must be performed by a different provider. Tooth designation is required.	No	$48.34 **(effective 8/1/03)**

MAA does not cover extraction of asymptomatic teeth. [WAC 388-535-1100(2)]

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Adjunctive General Services

Unclassified Treatment

D9110	**Palliative (emergency) treatment of dental pain – minor procedure** • Emergency palliative treatment is: ✓ Covered only when no other definitive treatment is performed on the same day; and ✓ Covered once per client, per day. • A description of the treatment performed must be documented in the client's record. • Not allowed when performed on the same date as root canal therapy.	No	$45.00

Procedure Code	Description/Limitations	Prior Auth?	10/1/03 Maximum Allowable 21 yrs & up

Anesthesia

- MAA covers the following anesthesia services as follows:

  General Anesthesia

  - For treatment of adults who are eligible under the Division of Developmental Disabilities;
  - When medically necessary for those oral surgery CPT procedure codes listed on pages F.5-F.15;

  Conscious Sedation

  - For treatment of adults who are eligible under the Division of Developmental Disabilities;
  - When medically necessary for those oral surgery CPT procedure codes listed on pages F.5-F.15 and those surgical extraction CDT codes listed on page E.35;

- MAA covers the above anesthesia services when the anesthesia is administered by:

  - An oral surgeon;
  - An anesthesiologist;
  - A dental anesthesiologist;
  - A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH); or
  - A dentist who has a current conscious sedation permit or a current general anesthesia permit from DOH.

- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.

- When billing for general anesthesia, show the actual beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

- MAA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist:

  $101.15 + [TIME UNITS X $20.23] = MAXIMUM ALLOWABLE FEE
  Note: Every 15 minute increment or fraction equals one time unit.

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up
	• Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to MAA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see *Important Contacts*). • Documentation of medical necessity must be kept in the client's file.		
D9220	Deep sedation/general anesthesia MAA's reimbursement for D9220 **includes the total time** – not just the first 30 minutes as specified in the CDT book. See previous page for further information. **(A General Anesthesia permit is required to be on file with MAA from the provider/performing provider.)**	No	**By Report**
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide MAA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	$6.18 **DDD clients only**
D9241	Intravenous conscious sedation/analgesia **Conscious sedation with parenteral agents.** **(A Conscious Sedation permit is required to be on file with MAA from the provider/performing provider.)**	No	$50.00
D9248	**Non-intravenous conscious sedation** Conscious sedation with multiple oral agents. **(A Conscious Sedation permit is required to be on file with MAA from the provider/performing provider.)**	No	$50.00

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Professional Visits

- Nursing facilities must provide dental-related necessary services per WAC 388-97-012.
- No additional payment will be made for multiple calls for patients in nursing facility settings.
- Procedures including evaluations or assessments must be billed with the appropriate procedure codes.
- A referral for dental care must be documented in the client's record. This referral may be initiated by the client, client's attending physician, facility nursing supervisor, or client's legal guardian when a dental problem is identified.
- The client or guardian has freedom of choice of dentist in the community. The on-staff dental provider may be called when the patient has no preference and concurs with the request.
- MAA does not cover Medicaid-eligible clients in nursing facilities who receive services that exceed those covered under this program. Services outside this program should be arranged by the nursing facility and may be covered under their rate structure.

D9410	**House/extended care facility call** Allowed once per day, per facility, per provider. **Limited to two total calls per day**.	No	$31.53
D9420	**Hospital calls (includes emergency care)** Allowed once per day, per client, per provider. Not covered for routine preoperative and postoperative visits.	No	$31.53

Drugs

D9630	**Other drugs and/or medicaments** Use this code when billing for pharmaceuticals. Payable only when billed with D9220, D9241, or D9248. MAA limits this procedure code to parenteral and multiple oral agents for conscious sedation and general anesthesia agents only.	No	**By Report**

Procedure Code	Description/Limitations	Prior Auth?	Maximum Allowable 21 yrs & up

Miscellaneous Services

D9920	**Behavior management** • Requires the assistance of **one additional dental professional staff** • A description of behavior management procedures performed must be documented in the client's record.	No	$27.00 **DDD clients only**